

Gordon-Conwell Theological Seminary
Charlotte Campus

When Wounds Are Fresh: *Hospital Chaplaincy in Times of Trauma*

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INTRODUCTION

Trauma: The ‘Big Picture’. Trauma surrounds and envelops us. It fills our headlines and screens. It shatters childhoods and schoolgrounds, sanctuaries and communities. Trauma can terrify or transfix us, paralyze or propel us. In ways known and unknown, trauma transforms us.

The English word – *trauma* – is derived from the Greek word for “wound,” used in its original language and context to denote physical injuries.¹ A New Testament biblical use is found in the account of several “itinerant Jewish exorcists” who tried to mimic the apostle Paul’s healing ministry by invoking the name of Jesus to drive an evil spirit from a man. Instead of submitting, the possessed man attacked and overpowered the exorcists who fled “naked and wounded” (Acts 19:11-16) – *traumatized*.

The broad usage of the term “trauma” today encompasses multiple forms of injury including psychological, emotional, and spiritual wounds. Professional counselors and popular writers alike have used a potpourri of descriptive phrases in an effort to capture and convey the nature of trauma and its profound impact on individuals, families, and communities. It has been observed, for example, that “trauma attacks the soul,”² and, “trauma is loss with the volume turned way up.”³

Trauma is also *universal*, striking individuals, families, communities, and nations without regard to time, place, class, continent, or culture. “Regardless of racial or ethnic background,” says one observer, “trauma transcends the external differences and reminds us that we are of ‘one blood’ – thus making trauma a “trans-cultural” phenomenon.”⁴

¹ Merriam-Webster Dictionary, s.v. “Trauma,” accessed March 24, 2019 <https://www.merriam-webster.com>.

² Paul Valent, in the Foreword to *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles Figley (Thousand Oaks, CA: SAGE Publications, 2012), accessed March 22, 2019, WorldCat Discovery.

³ Nancy Reeves, “North America on a couch,” in *In the Aftermath: What September 11 is Teaching Us about Our World, Our Faith, & Ourselves*, ed. James Taylor (Kelowna, BC: Northstone Publishing, 2002), 126.

⁴ Rodney L. Cooper, Professor at Gordon-Conwell Theological Seminary, in email to author, April 1, 2019.

Clinical definitions of trauma have evolved in recent years. In the Fifth Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V), published in 2013, the definition of events that qualify as traumatic is substantially narrowed from previous editions of the manual. Pai and colleagues note that the DSM-V requires "actual or threatened death, serious injury, or sexual violence" in order for an event to be considered traumatic. The latest manual, according to Pai et. al., also excludes many medical events from the trauma definition, including heart attacks and illnesses that while life-threatening, are considered "non-immediate" and "non-catastrophic."⁵ This view is in contrast to broader definitions of trauma recognized by many mental health practitioners and researchers. Briere and Scott, for example, identify eight specific kinds of major trauma, ranging from natural disasters and torture, to house fires and car accidents.⁶

More than 25 years have passed since Judith Herman offered what remains a striking and poignant overview of the devastating wounds that trauma delivers:

Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis.⁷

The field of trauma studies continues to flourish, with much emphasis in recent decades on trauma exposure, posttraumatic stress, trauma therapy, and recovery. "Traumatology" – a term originally associated only with physical wounds and surgery – now encompasses a full range of

⁵ A. Pai, A.M. Suris and C.S. North, "Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations *Behavioral Sciences* 7, no. 1 (2017): National Institutes of Health, accessed January 22, 2019.

⁶ John Briere and Catherine Scott, *Principles of Trauma Therapy: A guide to symptoms, evaluation and treatment* (Thousand Oaks, CA: Sage Publications, 2006), 4-9.

⁷ Judith Herman, *Trauma and Recovery* (New York: BasicBooks, 1992), 51.

physical, psychological, social, behavioral, and relational dynamics.⁸ The brief overview of trauma presented above serves as context for this paper's specific topic.

Scope & Focus of This Paper: *Hospital Chaplaincy in Times of Trauma*. This paper explores the dynamics of chaplaincy in situations where trauma unfolds in the hospital setting. Clinical, psychological, emotional, spiritual, and theological considerations are addressed. A primary purpose of this paper is to examine the actual practice of chaplaincy in hospital trauma scenarios. The author presents a model for trauma chaplaincy based on four key aspects of ministry in emergency rooms and other units where patients, their family members, and hospital personnel encounter trauma. The paper also presents research and observations on how trauma sufferers and trauma chaplains may be impacted by the lasting effects of traumatic injuries and illnesses, and by 'secondary' or 'vicarious' trauma exposure. The paper also briefly notes a few additional theological and practical considerations for trauma chaplaincy.

Terminology in this Paper. In many instances, the author uses the term "trauma" in the broad sense, to include the physical, psychological, emotional, and spiritual 'wounding' that traumatic experiences can inflict. This usage views trauma in essentially the same manner as do Briere and Scott, who conclude that "an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources."⁹ This definition overlaps with common usage of the word "crisis," which James and Gilliland define as "a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms."¹⁰ Stone asserts that "a crisis is what happens within people,

⁸ Omar Reda and Charles Figley, "Traumatology," in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles Figley (Thousand Oaks, CA: SAGE Publications, 2012), accessed March 25, 2019, WorldCat Discovery.

⁹ Briere and Scott, 4.

¹⁰ Richard James and Burl Gilliland, *Crisis Intervention Strategies*, (Boston: Cengage Learning, 2017), 3.

what takes place within families” in response to a “precipitating” external event.¹¹ This paper includes frequent use of the term *crisis* when quoting sources, including those from the field of crisis counseling and intervention. The author at times also employs the terms “crisis” and “trauma” together, when the point being addressed has broad application across various caregiving scenarios.

This paper treats *hospital chaplaincy* as the provision of spiritual and emotional care and support to patients, their family members, and hospital staff by professionally-certified and/or trained individuals. Handzo notes a “lack of definitional clarity” among chaplains and other practitioners surrounding the terms *chaplaincy care*, *pastoral care*, and *spiritual care*. The purposes of this paper are achieved without focusing on such debates or distinctions. In accordance with Handzo’s summary, however, it should be noted that the term “spiritual care” is understood by many today to connote an approach to human health and wholeness that is broader and more encompassing than the traditional functions of “pastoral care.”¹²

In addition to the targeted field of hospital chaplaincy, research for this paper is drawn from several related disciplines including psychology, trauma therapy, pastoral care, crisis counseling and intervention, and disaster chaplaincy. The author has attempted to fairly and judiciously apply such material to the paper’s specific focus.

The spiritual and theological matters addressed in this paper are viewed primarily from within the Christian tradition, and the author is a lifelong Protestant. An adequate consideration of trauma chaplaincy from the perspectives of other major faith traditions is beyond the scope of this paper. This fact in no way diminishes what other religious and spiritual contexts offer to the

¹¹ Howard Stone, *Crisis Counseling* (Minneapolis, MN: Augsburg Fortress Publishers, 1993), 21.

¹² George Handzo, “The Process of Spiritual / Pastoral Care,” in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen B. Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 24.

understanding and practice of hospital chaplaincy.

The Christian Scriptures are filled with accounts of traumatic events. One might premise an entire study of trauma based on a biblical narrative such as the Fall, the Exodus, the Exile, Gethsemane, or the Cross. While this paper does not attempt to weave a unifying Scriptural narrative throughout the discussion, relevant biblical references and illustrations are included. In addition, the recurring themes of *wounds* and *wounding* provide a cohesive framework across the chapters that follow. Scripture references, unless otherwise noted, are from the English Standard Version Bible.¹³

¹³ The Holy Bible, English Standard Version, copyright 2001 by Crossway, a publishing ministry of Good News Publishers.

Chapter 1

PSYCHOLOGICAL, EMOTIONAL, AND CLINICAL DYNAMICS OF HOSPITAL TRAUMA CHAPLAINCY

A pager alert goes off. A hospital chaplain awakens from a light sleep in the on-call room and reaches for the device. “Trauma 1, GSW, ED, 5-min out.” It’s just after 3:00 a.m. Quickly the chaplain splashes cool water on her face, takes a few moments to gather herself, and begins to walk briskly through echoing hospital corridors to the emergency department. As she arrives in the trauma bay, medics move in swiftly, transporting a young man with heavy bandages across his bare chest and abdomen. A medic shouts: “28 year-old male, multiple gunshot wounds to the chest, BP 80 over 55, heavy blood loss...” Ten emergency room personnel circle around the patient in a trauma room. The chaplain feels her own heart rate increase.

Chaplaincy Amid Fresh Wounds and Clinical Environments. Scenarios such as the one above thrust the hospital trauma chaplain into what Dykstra calls “front-line pastoral ministry of the trenches, far removed from the traditional ‘sanctuary’ of the churches.”¹ The allusion to warfare is not without merit. In the early stages of a hospital-based trauma, the physical wounds of patients are fresh and may be gaping. In addition, the trauma patient (if conscious) and gathering family members experience shock, confusion, and an onslaught of emotional and spiritual distress that may bear some semblance to that encountered by a badly-wounded soldier and his or her comrades. The trauma chaplain steps into such scenarios as a spiritual and emotional first responder.

Hospital trauma chaplaincy occurs in a unique environment and under a distinctive set of medical and clinical procedures and protocols. Individuals who arrive into this environment due to a medical trauma find themselves in a setting that can be highly disorienting. Dykstra

¹ Robert Dykstra, “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss,” *The Journal of Pastoral Care* XLIV, 2 (Summer 1990): 145, accessed May 12, 2017, ATLAS.

compares this to the experience of foreigners who were forced by famine, warfare, or other crises to take refuge within the ancient Israelite community. “Those who migrate to the emergency room in their time of crisis come as outsiders into a previously formed community,” Dykstra observes. This clinical community functions with its own set of rules and procedures that can be likened to the detailed laws that governed post-exodus Israel.² Bidwell, adopting Dykstra’s analogy, adds that patients or family members who ‘sojourn’ into a hospital emergency room or intensive care unit “may feel isolated or surrounded by a culture and language that cannot be understood.”³

Terri Villagos, who served as an emergency department chaplain at a Level 1 trauma center in Charlotte, North Carolina, identifies another key aspect of a trauma victim’s entry into the world of hospital trauma care. “Their control of the situation is taken,” says Villagos. She describes a typical emergency room scene in which “a bunch of strangers pick you up and start poking holes in you and pumping stuff into you, and you really don’t have a say-so.” Standard clinical procedures in a trauma case, Villagos notes, can include cutting-off the patient’s clothing and applying physical restraints. “All your humanity is being stripped from you,” Villagos summarizes.⁴ Dykstra observes that in a case of severe trauma, when death threatens, the medical staff’s sole intent is to preserve the life of the patient. This singular focus can leave a conscious trauma patient or a patient’s family members feeling ‘objectified’ during the peak of the event. Dykstra notes that at such times, it is the hospital chaplain who can offer hospitality to those who have been become unexpectedly swept up in the “regimented” world of trauma emergency care.⁵

²Dykstra, 145.

³Duane Bidwell, “Developing an adequate ‘pneumatraumatology’: understanding the spiritual impact of traumatic injury,” *The Journal of Pastoral Care & Counseling* 56, 2 (2002): 136, accessed July 14, 2017, ATLAS.

⁴ Terri Villagos, interview by author, Charlotte, NC, June 25, 2018.

⁵ Dykstra, 145.

The atmosphere during a hospital-based major trauma event is intense for all parties, including trauma patients who still have awareness in the moment, their family members, and the medical team. Often, this intensity is permeated with the looming possibility or likelihood of death – will the trauma victim *survive* the fresh and threatening physical wounds of a weapon, traffic collision, fall, heart attack, or countless other potentially-fatal injuries or medical events? When a sudden death does occur, the chaplain is often called upon to help family members – and perhaps the clinical staff – navigate the overwhelming and unpredictable initial dynamics of traumatic loss and emerging grief.

Chaplaincy Amid Sudden Death and Emerging Grief. The sting of sudden death can strike at any time and on any unit of a hospital. Personnel in the emergency department, intensive care, and labor and delivery units are well-acquainted with this experience. The psychological and emotional responses and behavioral dynamics surrounding such deaths deserve special awareness, understanding, and intervention on the part of spiritual caregivers. Worden identifies several distinctive ways in which a death that occurs without warning may impact family members and other survivors, including feelings of “unreality” and “helplessness” about the loss. Survivors may also experience a sense of guilt, a “need to blame” someone for the death, feelings of agitation, or even explosive anger. Worden adds that a sudden death “is an assault on our sense of power and on our sense of orderliness.” According to Worden, the resulting sense of rage can even prompt a survivor to lash out with violence or a ‘death wish’ against hospital personnel.⁶

Marian Cooper, a chaplain at a Level 1 trauma center in Charlotte, has observed the dynamics of sudden, traumatic death and the initial waves of grief among family members and

⁶ William Worden, *Grief Counseling and Grief Therapy* (New York: Springer Publishing Company, 2009), 187-189.

clinical staffers. Cooper describes one case in which a mother shot her two young children, then committed suicide. “That tore the ED [emergency department] up,” Cooper recalls, adding, “they tried to revive these kids over and over and over again, and they died...I mean, the ED doctors were tearful.” Furthermore, according to Cooper, a police detective violated hospital protocol by confirming the children’s deaths to their father before the ED physician was able to do so. The father, Cooper says, “jumped all over the doctor,” alleging that the doctor hadn’t done enough to save the children.⁷

The dynamics outlined above are reminiscent of Kubler-Ross’s classic ‘five stages of grief.’⁸ James and Gilliland rightly note that the original intent for the model was to help caregivers understand the needs and feelings of dying patients.⁹ James and Gilliland highlight Kubler-Ross’s work in the broad context of bereavement dynamics. However, their observations on the first three of these commonly-cited grief stages are particularly relevant in cases of hospital trauma and sudden death. In such cases, the manifestations of grief will often be seen in family members of a patient who is severely wounded or ill, dying, or deceased. James and Gilliland note that during the “Denial and Isolation” stage, a patient (or we could add, family members) “may generate a temporary protective denial system,” cutting themselves off from confirmation of a terminal condition (or death). In the “Anger” stage, denial may give way to demonstrations of “hostility, rage, envy, and resentment,” in an effort to gain some degree of respect and control in the face of death. Similarly, in the “Bargaining” stage of grief, patients may “bargain with physicians or bargain with God for an extension of life, one more chance, or

⁷ Marian Cooper, interview by author, Charlotte, NC, June 23, 2018.

⁸ Elisabeth Kubler-Ross, *On Death and Dying*, (New York: Simon & Schuster, 2014), 62-178, Scribd. [Kubler-Ross’s seminal 1969 work identifies five stages of grief or the dying process as: 1) Denial and Isolation, 2) Anger, 3) Bargaining, 4) Depression, and 5) Acceptance.]

⁹ Richard James and Burl Gilliland, *Crisis Intervention Strategies*, (Boston: Cengage Learning, 2017), 424.

time to do one more thing.”¹⁰ Likewise, family members may engage in similar efforts to ‘bargain’ for a desired outcome. The chaplain who possesses knowledge about common responses to grief will be better equipped to provide emotional and spiritual support in hospital trauma situations that result in a sudden death.

The present chapter highlights key clinical, psychological, and emotional dimensions that surround trauma chaplaincy. By its very nature, though, chaplaincy also deals with another crucial dimension – that is – the spiritual and theological dynamics that emerge or lurk amid hospital trauma scenarios. In her seminal work on trauma, Herman poignantly portrays this reality: “Wounded soldiers and raped women cry for their mothers, or for God. When this cry is not answered, the sense of basic trust is shattered. Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life.”¹¹ Trauma and sudden death are spiritual, as well as physical, psychological, and emotional events. We turn next to highlight the relationship between trauma and the spiritual and theological understandings, responses, and questions that typically emerge during hospital trauma events.

¹⁰ James and Gilliland, 424.

¹¹ Judith Herman, *Trauma and Recovery* (New York: BasicBooks, 1992), 52.

Chapter 2

SPIRITUAL AND THEOLOGICAL DYNAMICS OF HOSPITAL TRAUMA CHAPLAINCY

The Intersection of Trauma and Spirituality. In a hospital emergency department or the ICU, the lines between life and death are often very thin, and sometimes, blurry. As shock, anger, grief, and other responses emerge during hospital trauma events, statements and questions arise that are *spiritual* in their essence and often *theological* in their framing. McCormick and Hildebrand note that patients or family members who are dealing with the immediate shock of trauma “may ask very simple faith related questions” such as “Why did this happen to me?” and “Where is God?”¹

Theological questions follow naturally in the wake of trauma. Writing in the aftermath of the September 11, 2001 terrorist attacks, Willimon observed that “a great trauma makes theologians of us all.” He also recalled an interesting reaction among clergy members in the days after the 9/11 attacks: “More than one fellow preacher told me that, after spending a lifetime complaining that no one listens to preachers, it was truly terrifying suddenly to be thrust into a moment when everyone *wanted* to hear a sermon.”² Similarly, the hospital trauma chaplain may be called upon or have opportunity to enter into a void that other caregivers or support systems are not equipped to fill. Bidwell highlights this prospect by asserting that while psychological and social interventions may help relieve both present and future stress that trauma victims encounter, such interventions do “not provide nor claim a solid basis for understanding and

¹ Steven McCormick and Alice Hildebrand, “A Qualitative Study of Patient and Family Perceptions of Chaplain Presence During Post-Trauma Care,” *Journal of Healthcare Chaplaincy* 21, (2015): 73, [http:// dx/doi.org/10.1080/08854726.2015.1016317](http://dx.doi.org/10.1080/08854726.2015.1016317).

² William Willimon, “What September 11 Taught Me about Preaching,” in *In the Aftermath: What September 11 is Teaching Us about Our World, Our Faith, & Ourselves*, ed. James Taylor (Kelowna, BC: Northstone Publishing, 2002), 104.

addressing the spiritual impacts of a sudden, and often violent, traumatic injury.”³

Trauma, spirituality, and theology are inextricably intertwined. And yet, as Dykstra observes, in situations of devastating trauma, “chaplains find themselves theologically ‘levelled,’” and “theological certitudes are suddenly all up for grabs.”⁴ In the hospital emergency or intensive care setting, theological degrees and training and traditional means of providing pastoral support – such as prayer and reciting Scriptures – may seem painfully impractical, inadequate, or even inappropriate. When a traffic accident has taken a teenager from her parents, or an expectant mother has suffered a miscarriage, the stark realities of the trauma and the accompanying emotional and spiritual pain produce questions that defy conventional theological responses. Bidwell sees the realm of trauma as a “wilderness,” fraught with “temptations.” In this wilderness, Bidwell states, trauma victims and their families may be tempted, among other responses, “to reject or condemn God for what has happened; to put all of their hope in medical technology and physicians; to see continued life, at whatever cost, as the only good option; to value their life and loved ones more than they value God.”⁵

Drawing from the principles of early Christian asceticism, Bidwell also offers a view of trauma and spirituality built around the notion that “human beings experience three levels of spirituality.” These three realms include what Bidwell calls the spiritualities of “light,” “darkness,” and “cloudiness.” At the “light” level, according to Bidwell, “people believe they understand God clearly, and their faith is unquestioning.” In the “spirituality of darkness,” there is a direct awareness of and “contact” with God, though it cannot be expressed through language.

³ Duane Bidwell, “Developing an adequate ‘pneumatraumatology’: understanding the spiritual impact of traumatic injury,” *The Journal of Pastoral Care & Counseling* 56, 2 (2002): 136, accessed July 14, 2017, ATLAS.

⁴ Robert Dykstra, “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss,” *The Journal of Pastoral Care* XLIV, 2 (Summer 1990): 151, accessed May 12, 2017, ATLAS.

⁵ Bidwell, 137.

But for Bidwell, it is a middle or “second” level of spirituality – the “spiritually of cloudiness” – that trauma patients and their families often encounter. In this realm, “God may be an ambiguous, shadowy figure.” In this cloudiness, according to Bidwell, “individuals begin to realize that the images of God and understandings of faith that served them well in the spirituality of light are not sufficient for all of life’s events.”⁶

Rambo also discusses the theological challenges posed by trauma and suffering, and offers the provocative assertion that “in the midst of trauma, conceiving of divine presence is impossible.”⁷ Rambo proposes that “trauma forces us beyond a familiar theological paradigm of life and death,” that is, the paradigm portrayed in the Christian narrative concerning the Cross and Resurrection. Instead, according to Rambo, trauma places theological thinking on what she calls “the razed terrain of what remains” in trauma’s wake.⁸ Rambo’s examination of the intersection between trauma and theology is anchored in the timeless dilemmas of human suffering and theodicy, to which we turn our attention next.

Hospital Trauma: Suffering, Theology, and Theodicy. The search for suitable perspectives on the presence of pain, human suffering, and evil in the world is as old as recorded history. The dilemma has vexed theologians and people of faith for millennia. This paper seeks neither to shed new light on nor enter into the debate surrounding the broad question of theodicy (i.e. - *a response to the problem of evil in the world that attempts logically, relevantly and consistently to defend God as simultaneously omnipotent, all-loving and just despite the reality of evil.*⁹) Rather, our purpose here is to identify the presence and place of the theological questions that often swirl

⁶ Bidwell, 139-140.

⁷ Shelly Rambo, “Spirit and Trauma: A Theology of Remaining,” *Interpretation: A Journal of Bible and Theology* Vol. 69 (I) (2015): 18, accessed May 21, 2018, <http://dx.doi.org/10.1177/0020964314552625>.

⁸ Rambo, 19.

⁹ Stanley Grenz, David Guretzki & Cherith Nordling, s.v. “theodicy,” *Pocket Dictionary of Theological Terms*, (Downers Grove, IL: InterVarsity Press, 1999).

around the work and ministry of the trauma chaplain. This recognition is a vital first step toward providing effective spiritual care when sudden death or other hospital-based trauma ignites stark and difficult spiritual and theological questionings or expressions.

Zurheide notes that “pain is intrinsically alienating,” often making people feel like “strangers” to themselves and others. “Sometimes,” he adds, “it can even make God seem like a stranger, as this One upon whom we have relied through the years may now feel distant or somehow disconnected.”¹⁰ Hospital-based trauma and suffering often serve as a breeding ground for such feelings and theological questioning. Rev. Dane Sommer, founder of the Pediatric Chaplains Network, identifies several commonly-expressed questions about the nature and activity of God amid suffering. Sommer recalls his work in one children’s hospital where he frequently fielded questions such as: *Where is God in the midst of all the suffering that occurs in a children’s hospital? Why does suffering exist if God is present in our lives? Why is God testing me with this enormous burden? And, What have I done to be punished like this?*¹¹

Some trauma patients or their family members will put forth ‘answers’ to profound theological questions, based upon their own understandings of God. Zurheide places such responses into four categories, including answers that are *deterministic* (“It’s God’s will”), *didactic* (“God is teaching me something”), *athletic* (suffering is a “training or testing experience from God”), or, *disciplinarian* (God “uses pain and suffering to punish people for wrongs and sins committed”).¹² Similar themes emerge in a 2007 essay that summarizes theological responses to several natural disasters including the “Boxing Day tsunami” in Asia in 2004 and

¹⁰ Jeffrey Zurheide, *When Faith Is Tested: Pastoral Responses to Suffering and Tragic Death*, (Minneapolis, MN: Fortress Press, 1997), 16.

¹¹ Dane Sommer, “Pediatric Chaplaincy,” in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen B. Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 262-263.

¹² Zurheide, 20-25.

Hurricane Katrina's strike on the U.S. Gulf Coast in 2005. Sugirtharajah narrows such responses to two types: "One is to attribute the disaster to an angry deity who is seen as mean and vengeful, and the other is to blame the disaster on arrogant, frail, sinful and irresponsible humanity."¹³

An individual's theological response to trauma and suffering will likely reflect long-held views of and assumptions about God. Sutherland examines 'God-talk' that people use during times of crisis, trauma, grief, and suffering. Writing from a Christian perspective, Sutherland asserts that "in times of trouble and sorrow many of us may choose the God-talk of our roots, seeking comfort in the patterns learned in childhood, or upon first becoming a Christian."¹⁴

The trauma which brings patients and their family members to hospitals or develops during a hospitalization is varied in nature, and the psychological, spiritual, and theological responses of sufferers will likely reflect these differences. Mason observes, for example, that suicide is "uniquely difficult" for survivors to deal with, in that it brings distinctive forms of shock, fear, stigma and guilt. Furthermore, Mason notes that "a suicide death can be even more excruciating for a Christian because all the whys are directed to God." Baffling theological and other questions, according to Mason, "can produce a crisis of faith" for family members and other suicide survivors.¹⁵

Gillespie maintains that man-made traumatic events such as the 9/11 terror attacks pose a distinct theological challenge. According to Gillespie, "while the theodicy questions about evil can emerge from natural disasters, it is the trauma from human atrocities that raises the most

¹³ R.S. Sugirtharajah, "Tsunami, Text and Trauma: Hermeneutics after the Asian Tsunami," *Biblical Interpretation*, 15 (2007): 125, accessed March 6, 2019, ATLAS.

¹⁴ Anne Sutherland, "Worldframes and God-talk in Trauma and Suffering," in *The Journal of Pastoral Care* 49, No. 3 (Fall 1995): 281, accessed April 9, 2017, ATLAS.

¹⁵ Karen Mason, *Preventing Suicide: A handbook for pastors, chaplains, and pastoral counselors* (Downers Grove, IL: InterVarsity Press, 2014), 139-144.

intense questions.”¹⁶ In discussing the “features” of sudden death and common responses by persons who are quickly caught up in grief, Worden notes the strong need among survivors to understand why the death occurred – and – to find meaning in the loss. As noted in Chapter 1, a sudden or traumatic death can also produce a need to place blame. According to Worden, for some grieving survivors, “God is the only available target for their recriminations.” In such circumstances, Worden adds, people may declare, “I hate God.”¹⁷

At other times, in situations of an impending death, for example, family members may verbalize what appears to be strong faith and cry out to God for intervention. When one 25-year-old woman was on the verge of death in an intensive care unit, a physician told family members, “There’s nothing we can do – I’m sorry.” A female cousin of the patient forcefully responded, “No! Don’t say there’s nothing! There’s got to be something...*anything!*” A short time later, the cousin, who sat on the floor in a hallway just outside the ICU family area, loudly exclaimed, “Come on God – do something! *They* can’t...*You* can!”¹⁸

Whether expressed positively, negatively, or with confusion and pleading – questions and statements relating to faith, theology, or concepts of God or the divine are likely to mingle with the fresh physical and emotional wounds of hospital trauma. For the chaplain, being attuned to these spiritual and theological dynamics is among the key factors in providing good care and support in trauma situations. Additional keys to such caregiving are addressed in the following chapter as we examine the practice of chaplaincy in a hospital trauma setting.

¹⁶ C. Kevin Gillespie, “Terror, Trauma, and Transcendence: Pastoral Ministry after 9/11,” *New Theology Review* 17, No. 1 (February 2004): 21, accessed January 21, 2018, <http://newtheologyreview.org/index.php/ntr/issue/view/34>.

¹⁷ William Worden, *Grief Counseling and Grief Therapy* (New York: Springer Publishing Company, 2009), 189-190.

¹⁸ Based on a pastoral care encounter by the author as a chaplain intern during a unit of Clinical Pastoral Education at an acute care hospital in North Carolina in August 2015.

Chapter 3

THE PRACTICE OF CHAPLAINCY IN HOSPITAL TRAUMA SCENARIOS

Essential Qualities, Roles, and Pastoral Care Images for Trauma Chaplains. Professional organizations that train, certify and support healthcare chaplains identify numerous outcomes and competencies considered to be essential qualifications for the profession. Competencies include the ability to: “triage and manage crises in the practice of spiritual care; provide spiritual care to persons experiencing grief and loss; facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups; facilitate theological/spiritual reflection for those in one’s care practice.”¹ As chaplain interns and residents progress through multiple units of Clinical Pastoral Education, they must demonstrate, among other competencies, “a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution / transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.”² These professional standards and competencies highlight fundamental chaplaincy skills that are essential for ministry in hospital trauma cases.

Effective listening is a quintessential skill for chaplains. It is beyond the scope of this paper to provide an adequate discussion of techniques for supportive listening. Worth noting, however, are the broad principles that Kidd identifies for effective listening and responding. These include the use of open-ended comments or questions, staying “in the moment,” and remaining as objective as possible while listening.³

¹ “Common Qualifications and Competencies for Professional Chaplains (2016-2017),” Board of Chaplaincy Certification, Inc., accessed March 8, 2019, <http://www.professionalchaplains.org/content.asp?pl=198&contentid=198>.

² “Standards 311-312 Outcomes of CPE Level I/Level II Programs,” Association of Clinical Pastoral Education Manuals (2016), accessed March 8, 2019, <https://www.manula.com/manuals/acpe/acpe-manuals/2016/en/topic/standards-311-312-outcomes-of-cpe-level-i-level-ii-programs>.

³ Robert Kidd, “Foundational Listening and Responding Skills,” in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen B. Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 93-94.

The trauma chaplain provides care in physical and emotional territory that can be alternately or simultaneously raw, intense, chaotic, or somber. Amid a swirl of medical staff, the chaplain has a unique role – “part of the staff and yet, separate from it,” in Bodemann’s view. Functioning alongside but apart from the clinical “chain of command” enables the chaplain to be “eye-to-eye with everyone: nurses, doctors, aides, patients, families,” according to Bodemann.⁴ She also notes the “hierarchical” nature of hospital emergency departments and concludes that, paradoxically, in such an environment “there is no place for the chaplain, and every place for the chaplain.” Bodemann envisions the ED chaplain as “the one person who can be a presence, a witness, a guide.”⁵ McCormick and Hildebrand bring an additional nuance to the notion of “guide,” suggesting the need for fluidity and a reciprocal dynamic in the role of the chaplain. This involves seeking to understand “the changing patient needs of each moment, to join patients where they are and then move with them, sometimes as guide and sometimes as follower.”⁶ The same perspective can be applied to the chaplain’s interactions with the family members of trauma victims.

Dykstra similarly views the chaplain as a “member of the hospital community,” one who can “move back and forth between the treatment team and waiting family, passing information in both directions.”⁷ Dykstra develops the metaphor of the “intimate stranger” as it relates to chaplain care in cases of sudden, traumatic loss. He elaborates three aspects of this metaphor

⁴ Christina Bodemann, “Seeing Eye to Eye: Becoming the Chaplain in the Emergency Department of a Level 1 Trauma Center,” *Journal of Emergency Medicine* (48), No. 6 (2015): 751, accessed May 23, 2018, SCEL from ClinicalKey.com by Elsevier.

⁵ *Ibid.*, 753.

⁶ Steven McCormick and Alice Hildebrand, “A Qualitative Study of Patient and Family Perceptions of Chaplain Presence During Post-Trauma Care,” *Journal of Healthcare Chaplaincy* 21, (2015): 73, [http:// dx/doi.org/10.1080/08854726.2015.1016317](http://dx.doi.org/10.1080/08854726.2015.1016317).

⁷ Robert Dykstra, “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss,” *The Journal of Pastoral Care* XLIV, 2 (Summer 1990): 149, accessed May 12, 2017, ATLAS.

including, 1) “Crisis as Stranger,” 2) “The Chaplain as Stranger,” and 3) “God as Stranger.”⁸ For Dykstra, the “strangeness” inherent in such encounters can in fact lend itself to helpful dynamics in the spiritual care process. For example, the “one meeting” nature of most hospital trauma chaplaincy encounters can foster a ‘freedom of expression’ for both the chaplain and the recipients of his or her care. For the suffering person, according to Dykstra, this dynamic may allow the freedom “to say or do whatever he or she needs to, knowing that because the chaplain is a stranger, the victim need not be held accountable forever for it.”⁹

Landry views professionally certified chaplains as “hosts, counselors, confidants, and friends to people who have been suddenly thrown into chaos.”¹⁰ Landry picks up on Dykstra’s “intimate stranger” theme, asserting that “the trauma chaplain soon becomes the family’s companion and intimate friend.” In this claim, Landry appears to extend and possibly stretch Dykstra’s metaphor by adopting the language of ‘friendship’ regarding the relationship between the chaplain and the trauma victim’s family.

Many other images or metaphors have been proposed in the effort to characterize the role of pastoral caregivers. Dykstra presents a helpful collection of essays on classical and contemporary pastoral care images such as Hiltner’s “The Solicitous Shephard,” Nouwen’s “The Wounded Healer,” and Hanson’s “The Midwife.”¹¹ These and other images offer helpful perspective to hospital chaplains in general, including those involved with trauma care. Zurheide, on the other hand, suggests that spiritual caregivers would do well to *avoid* certain pastoral “postures,” which he observed among community clergy members visiting hospital patients.

⁸ Dykstra, 139-152.

⁹ Ibid., 148.

¹⁰ Victor Landry, “Pastoral Care in a Trauma Center,” *Journal of Religion and Health* 35, No. 3 (Fall 1996): 211. Accessed May 24, 2018, JSTOR.

¹¹ Robert Dykstra, ed., *Images of Pastoral Care: Classic Readings* (St. Louis, MO: Chalice Press, 2005).

These pastoral styles, according to Zurheide, could be classified as the “Guru,” the “Doctor,” and the “Sunbeam.” Zurheide thus cautions caregivers against the temptations to be “walking treasuries” of theological wisdom for suffering patients, to profess medical expertise, or to seek primarily to “cheer up” the patient.¹² Zurheide’s insights are relevant in the hospital emergency room or other units where trauma occurs.

Zurheide also offers this valuable counsel that is of prime significance for the trauma chaplain: “Enter the spaces of the suffering with a sense of humility, even privilege.” Zurheide sees such spaces as ‘sanctuaries,’ to be neither comprehended nor controlled, but rather to be shared. “Bow your spirit as you enter,” advises Zurheide.¹³ The importance of the chaplain’s own state of mind and spiritual condition is also emphasized by Switzer, who states that “there is no better way to prepare for our meeting with the persons in the emergency of sudden death and/or critical illness and accident than to pray.” Switzer recommends that the chaplain’s petition to God be made on behalf of spiritual and medical caregivers alike, for their engagement together in the emergency, and for God’s guidance and activity in the situation.¹⁴

This section has offered a broad overview of the chaplain’s role, place, and posture during situations of hospital-based trauma. We are now prepared to examine key elements of the practice of trauma chaplaincy.

Key Elements of Hospital Trauma Chaplaincy: *The ‘PAWS’ Model.* This paper has noted the intense and often complex clinical, emotional, and spiritual dynamics that surround the ministry of the hospital trauma chaplain. Given these dynamics, no caregiving approach or model should be relied upon in a formulaic or ‘checklist’ fashion. However, many chaplains and Clinical

¹² Jeffry Zurheide, *When Faith Is Tested: Pastoral Responses to Suffering and Tragic Death*, (Minneapolis, MN: Fortress Press, 1997), 6-9.

¹³ Ibid., 10.

¹⁴ David Switzer, *Pastoral Care Emergencies* (Minneapolis, MN: Augsburg Fortress, 2000), 73.

Pastoral Education students have found it helpful to use one or more easily-remembered acronyms or similar devices that reflect key aspects of chaplaincy objectives, techniques, and interventions. This paper proposes one such model, using the acronym “PAWS” – built around four ministry elements that are vital for effective trauma chaplaincy: the Ministry of **P**resence, the Ministry of **A**ctions, the Ministry of **W**ords, and the Ministry of **S**ilence.¹⁵

The Ministry of Presence in Hospital Trauma Chaplaincy

The term “ministry of presence” can convey a range of meanings, with a variety of implications for the chaplain’s self-understanding and practice. Swain examines the concept of ‘presence’ through the lens of chaplaincy care provided at the temporary mortuary set up at ‘Ground fZero’ in New York City after terrorist-controlled planes plowed into and destroyed the twin World Trade Center Towers on September 11, 2001. Swain notes that the primary task of chaplains who served at the “T. Mort” was the ‘blessing of the remains’ of those who died in the disaster. These chaplains also ministered to the workers who carried out the grim task of recovering 9/11 victims’ bodies. Swain states that T. Mort chaplains whom she interviewed later described their work at Ground Zero as a “ministry of presence” that included several dimensions, “symbolic, actively compassionate, standing in solidarity, ritualistic, and at times sacramental.” In the words of one chaplain cited by Swain, “I was not there to teach anyone. I was not there to preach to anyone. I was there to just share the burden with them..and somehow to lighten the burden.”¹⁶

An effective ministry of presence requires a very open mental and emotional posture on

¹⁵ The author is unaware of the “PAWS” acronym being used elsewhere in this manner; ‘Google’ searches conducted on March 10, 2019 using the terms *Models of pastoral care “PAWS”*; *PAWS acronym for pastoral care – chaplaincy*; and *“PAWS” chaplaincy did not yield any evidence of such usage*.

¹⁶ Storm Swain, “The T. Mort. Chaplaincy at Ground Zero: Presence and Privilege on Holy Ground,” *Journal of Religion & Health* 50 (2011), 493, accessed May 16, 2018, DOI 10.1007/s10943-011-9519-z.

the part of the chaplain. Cisney and Ellers define a ministry of presence as “being fully present with another person, exhibiting a non-anxious, comfortable presence while demonstrating ‘God with us’ through the interconnectedness of the human interaction.” For Cisney and Ellers, this presence includes attentiveness to the safety and basic human needs of people in crisis, listening to and focusing on such persons, and maintaining a spirit of acceptance and non-judgment.¹⁷ Similarly, Wicks notes the value of allowing people who are experiencing major loss or other difficulties the freedom to “express their emotions without fear of undue reaction, rejection, or reprisals.” An accepting, nonjudgmental presence of this nature, according to Wicks, “can seem magical to the person experiencing trauma or distress.”¹⁸ During a crisis or trauma, suffering people may see a chaplain as what Sommer calls a “real-life representative of God.” Sommer states that chaplains seek to provide a presence in “emotionally draining” circumstances, and with “those who have given up on God.”¹⁹

An effective ministry of presence is a mutual and intimate experience, involving ‘shared space’ – emotional, spiritual, and often physical – between the caregiver and the traumatized or suffering patient or family members. In describing her work as an emergency department chaplain, Villagos states that her goal is to help a trauma victim feel “safe and loved” in the midst of their pain and distress. In the trauma treatment bay, says Villagos, “I’ll put on gloves, I’ll put on shoe covers, I’ll put on a face mask...whatever I need to get in here in that space with them.”²⁰ The importance of the chaplain’s close physical presence with trauma patients is also

¹⁷ Jennifer Cisney and Kevin Ellers, *The First 48 Hours: Spiritual Caregivers as First Responders* (Nashville: Abington Press, 2009), 33, Scribd.

¹⁸ Robert Wicks, *Night Call: Embracing Compassion and Hope in a Troubled World* (New York: Oxford University Press, 2018), 21.

¹⁹ Dane Sommer, “Pediatric Chaplaincy,” in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen B. Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 63.

²⁰ Terri Villagos, interview by author, Charlotte, NC, June 25, 2018.

stressed by Switzer. He advocates that pastoral caregivers in hospital emergency rooms directly address sick or injured patients and offer a physical touch and brief prayer when feasible and appropriate. Switzer acknowledges the potential awkwardness of such encounters: “We may feel very self-conscious in doing all of this with others in our presence, especially if the person seems to be unconscious.” Still, in Switzer’s view, “we simply have to go right ahead and do it anyway.”²¹

The trauma chaplain may also be caught up at times in a caregiving paradox. On one hand, there is a drive and desire to be present with and help suffering people. However, another side of human nature may pull in an opposite direction. In discussing the concept of *hospitality*, Nouwen observes that paying attention to a “guest” can be difficult because preoccupation with our “own needs, worries and tensions” can prevent us from “taking distance from ourselves in order to pay attention to others.”²² In the role as a hospital host to trauma victims and family members, such preoccupation may challenge the chaplain’s ability to be fully present with traumatized ‘guests’.

The power of a pure ministry of presence in caregiving situations, including those involving sudden and traumatic loss, is attested to again and again. And yet, chaplains and other pastoral caregivers also affirm the importance in many cases of extending one’s ministry beyond a mere presence. We address these more active elements of caregiving in the next two sections as we continue to outline the “PAWS” model of hospital trauma chaplaincy.

The Ministry of Actions in Hospital Trauma Chaplaincy

In the biblical parable of the Good Samaritan, the compassionate helper comes upon the victim of a roadside robbery and brutal beating. According to the narrative, the traveler goes to

²¹ Switzer, 74.

²² Henri Nouwen, “The Wounded Healer,” in *Images of Pastoral Care: Classic Readings*, ed. Robert Dykstra (St. Louis, MO: Chalice Press, 2005), 81.

the severely injured man, dresses his wounds, and applies oil and wine as agents of soothing and disinfecting²³ (Luke 10:34) before transporting him for further care. While the hospital chaplain will leave medical care to trained professionals, there are often practical ways in which he or she can provide physical as well as emotional support to trauma victims or their family members.

Writing from a pastoral ministry perspective, Cisney and Ellers suggest several ways of providing such care during the first 48 hours of a crisis. This ministry may include helping to meet basic needs or facilitating support from a trauma sufferer's faith community. Cisney and Ellers recommend that pastoral caregivers "assess what would be most helpful to the survivor and don't assume that you know what they need."²⁴ Similarly, Villagos bases her approach to trauma chaplaincy on her understanding of Maslow's 'hierarchy' of human needs, focusing first on meeting trauma victims' most basic needs, and then "earning the respect to work up higher."²⁵

An example of the trauma chaplain's practical role with patients and family members is seen in the emergency room ministry provided to a man whose wife of 26 years, a hospice patient, was deceased upon arrival at the ER. After some time being present with the grieving husband, the chaplain walked over to the side of the hospital bed where the woman's body rested as the husband sat in a chair nearby. Gently, the chaplain unlatched and slid down the railing that was acting as a physical and/or psychological barrier between the husband and his deceased wife's body. Immediately, the husband moved in close and touched the body. The man's grieving was facilitated by the chaplain's simple, caring, physical assistance.²⁶ In hospital trauma

²³ The Nelson Study Bible, NKJV, Earl Radmacher, Gen. Ed. (Nashville: Thomas Nelson Publishers, 1997).

²⁴ Cisney and Ellers, 105-106.

²⁵ Terri Villagos, interview by author.

²⁶ Based on the author's observations of a chaplain encounter during a unit of Clinical Pastoral Education in 2013 in Charlotte, NC.

scenarios, a chaplain will likewise encounter opportunities to provide practical support.

The chaplain's ministry of actions at times also encompasses more traditional pastoral functions, such as the conducting of religious rituals and the administration of sacraments. Zurheide notes that pastoral caregivers "seek to bring the presence and empathizing love of God, along with counsel and the resources of faith (Scripture, prayer, sacraments) to suffering people."²⁷ However, even seasoned pastoral caregivers will likely encounter challenges or dilemmas at times in carrying out traditional ministry functions in the context of hospital traumas, critical illnesses, and sudden deaths. One chaplain observes, for example, that "it is not uncommon for a family member, or even a staff member, to request prayer even though the patient/resident may not desire prayer."²⁸ Depending up his or her own religious context, a chaplain may also encounter an "internal struggle" when asked to perform certain religious rituals, such as baptism of an infant that is stillborn or dies shortly after birth. When such dilemmas arise, the "spiritual and emotional well-being" of care recipients can be seen as deserving primary consideration.²⁹

When the wounds of trauma are fresh, careful discernment may be required in order for the hospital chaplain to recognize the need for a simple ministry of *presence*, or the additional ministry of *actions*. Such discernment is also often necessary to distinguish the choice and timing of the ministry of *words* or the ministry of *silence*. These elements of the "PAWS" model for trauma chaplaincy are considered next.

The Ministry of Words in Hospital Trauma Chaplaincy

²⁷ Zurheide, 7.

²⁸ Gerald Jones, "Prayer and Ritual," in *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen B. Roberts (Woodstock, VT: Skylight Paths Publishing, 2012), 107.

²⁹ *Ibid.*, 114.

There is “a time to keep silence, and a time to speak,” the biblical writer keenly observed with timeless wisdom (Ecclesiastes 3:7). The truth of this counsel is made powerfully manifest in times of trauma and crisis. The hospital chaplain must discern throughout a trauma encounter both *whether* and *when* to speak, and if words are deemed timely – with *what* words to offer comfort, companionship and support to trauma victims or their family members. The next section of this paper will address those moments when words are discerned to *not* be necessary or desired. But, when words do seem appropriate, how can a chaplain enter into helpful verbal communication with persons who are experiencing a sudden loss?

Switzer encourages pastoral caregivers to initiate conversations with people who are experiencing a crisis by using “authentic, concrete words” that express a genuine reaction to the situation. He suggests the use of two basic initial questions with family members: “How are you doing?” and “Tell me what happened.” Switzer also notes the need for an *empathetic* response from the caregiver.³⁰ Regarding the relationship between empathy and words, Capretto offers the poignant observation that a person can “speak volumes and empathize little,” or, “empathize profoundly and offer few words.”³¹

Chapter 2 of this paper highlights the likelihood that trauma victims and grieving relatives will make statements or ask questions phrased in the language of theology or theodicy. We turn now to address ways in which a chaplain may wish to assess and respond to such language.

Zurheide asserts that when a sufferer poses what seems on the surface to be a theological question such as “Why me?” they may not actually desire a theological response or a “treatise on theodicy.” Rather, theological-sounding questions may be “rhetorical” in nature, serving to

³⁰ Switzer, 75.

³¹ Peter Capretto, “Empathy and Silence in Pastoral Care for Traumatic Grief and Loss,” *Journal of Religion and Health* 54, no. 1 (2015): 349, accessed April 12, 2017, DOI 10.1007/s10943-014-9904-5.

express grief and a need for companionship amid their loss.³² Gillespie concurs, stating that even when a trauma victim asks “Why did God allow this to happen,” the use of “rational” or theodicy-based responses by a pastoral caregiver may seem “too removed” from the sufferer’s current experience to provide any real comfort.³³ Rambo adds that “while theodicies provide logic for thinking through religious claims about God’s nature and human suffering, they do not function effectively to address and respond to suffering.”³⁴

Cautions against ‘over-theologizing’ a response to the questions of trauma sufferers, however, do not mean that hospital chaplains should always avoid theological dialogue with trauma victims, family members, or hospital staffers. Persons suffering or directly exposed to trauma, sudden loss, and grief may well view a chaplain as a representative of God or the divine – an available human being who is uniquely positioned to bring words of comfort and spiritual wisdom during a crisis. A trauma sufferer may thirst or even plead for the chaplain’s timely, comforting, and hope-inspiring ministry of words.

A fundamental principle for engaging in theological conversation with a trauma victim or their relatives is to first meet them on their own spiritual, religious, or theological ground. Sutherland observes that ministry in times of crisis, suffering, and trauma should be aimed at offering “comfort and hope,” in a way that respects the faith of both the recipient and the spiritual caregiver. In Sutherland’s view, to provide comfort means to affirm the faith that is implied “in the God-talk” used by persons experiencing a crisis. “Hope,” according to

³² Zurheide, 14-16.

³³ C. Kevin Gillespie, “Terror, Trauma, and Transcendence: Pastoral Ministry after 9/11,” *New Theology Review* 17, No. 1 (February 2004): 22, accessed January 21, 2018, <http://newtheologyreview.org/index.php/ntr/issue/view/34>.

³⁴ Shelly Rambo, “Spirit and Trauma: A Theology of Remaining,” *Interpretation: A Journal of Bible and Theology* Vol. 69 (I) (2015): 11, accessed May 21, 2018, <http://dx.doi.org/10.1177/0020964314552625>.

Sutherland, “is conveyed by remaining true to our own theology and God-talk.”³⁵

Scott examines spiritual and religious dynamics of trauma care by briefly surveying customs and rituals within six major religions practiced in the United Kingdom. She urges that all personnel who provide emergency care seek to “engage on a spiritual level with the real pain and suffering” of trauma patients and their family members. Care should be taken, according to Scott, to clearly understand the spiritual and religious needs of patients and their relatives and to avoid even inadvertently violating “deeply held spiritual tenets.”³⁶

As noted above, it is incumbent upon chaplains to seek discernment in responding to the religious framing or implications of statements and questions presented by suffering people. Zurheide asserts that for pastoral caregivers, this task of discernment involves determining “whether the interpretation to which a parishioner or patient is clinging is indeed life-giving and therapeutic or destructive.” Zurheide also cautions against dashing theological understandings that may be helping a sufferer to cope in the moment, simply because the pastoral caregiver finds the person’s view to be theologically-lacking.³⁷

Gerkin’s observations, grounded in crisis theory and principles of crisis ministry, are worth noting for our consideration of trauma chaplaincy. Gerkin advocates the use of an “incarnational model” of ministry, and a role that is stronger and “more prophetic, more active” than pastoral care images that emphasize the importance of “listening, reflecting, and accepting” a care recipient’s understanding of God and human suffering. Gerkin challenges the idea that pastoral

³⁵ Anne Sutherland, “Worldframes and God-talk in Trauma and Suffering,” in *The Journal of Pastoral Care* 49, No. 3 (Fall 1995): 281, accessed April 9, 2017, ATLAS.

³⁶ Tricia Scott, “Religion in trauma care: grand narratives and sacred rituals,” *Trauma* 12 (2010): 185-191, accessed April 9, 2017, 10.1177/1460408610376708.

³⁷ Zurheide, 19-20.

caregivers are able only to “suffer alongside” another person.³⁸ For Gerkin, the restoration of trust in God’s presence and providence is a key objective of crisis ministry.³⁹

Concerning cases of sudden, traumatic loss, Dykstra sees an inherent tension between, and limitations within, caregiver interventions that focus either psychological *or* theological responses. Assessing the chaplain’s dilemma, he asserts that such scenarios can create a “frustrating cycle” where “intervention is required but, in any ultimate sense, seems impossible.”⁴⁰ Dykstra concludes that in cases of catastrophic trauma and loss, “*active silence* finally may be all the chaplain can hope to offer.”⁴¹ The following section suggests that the place of appropriate silence in hospital trauma chaplaincy should not be discounted and that silence can in fact have powerful effects.

The Ministry of Silence in Hospital Trauma Chaplaincy

In the biblical narrative of Job, a righteous man loses his possessions, children, and health in a calamitous encounter with multiple and unfathomable traumas. Three friends collaborate to visit Job and “show him sympathy and comfort” (Job 2:11). Upon arrival, the three engage in culturally-appropriate demonstrations of mourning on Job’s behalf. And then, “they sat with him on the ground seven days and seven nights, and no one spoke a word to him, for they saw that his suffering was great” (2:13). The role of silence in supporting suffering people has been affirmed again and again. Wicks observes that when people speak of tremendous difficulties in their lives, they are likely not seeking answers from the listener. Rather, according to Wicks, “they are primarily looking for someone willing to sit with them in the darkness.”⁴²

³⁸ Charles Gerkin, *Crisis experience in modern life: theory and theology in pastoral care* (Nashville: Abington, 1979), 327.

³⁹ *Ibid.*, 35-36.

⁴⁰ Dykstra, 140.

⁴¹ *Ibid.*, 147 (italics added).

⁴² Wicks, 19.

A chaplain's decision to embrace an 'active,' intentional, and compassionate silence during a hospital trauma encounter can be viewed as a specific manifestation of the caregiver's broader ministry of presence. One chaplain recalls her approach in ministering to a father whose 18-year old son suffered an "opioid death" on Father's Day. The bereaved man "just grieved on the floor – he wailed for probably almost three hours," the chaplain remembers, adding, "I just decided in that moment to be silent, and to just be present."⁴³ A 'silent presence' in such times can be both healing and productive. Zurheide notes that silence during pastoral visits in general can be a "gift" which can elicit a range of emotions, including "guilt, pain, grief, or joy."⁴⁴

For the trauma chaplain, silence may pick up where other forms of ministry – including words of comfort – seem to fall short. Capretto examines the limits of empathy and empathic language in situations of traumatic grief and loss. He concludes that in relying too heavily on pastoral empathy, a caregiver 'robs' the grieving person of the opportunity to decide for themselves the meaning of a loss.^g In contrast, Capretto asserts that by relating through silence "the caregiver makes the decision to work *with* the inability of empathic language as opposed to trying ambitiously to overcome or surmount it."⁴⁵ Capretto is careful to distinguish "therapeutic silence" from that which is "indiscriminate" or used by a caregiver "predictably or formulaically." Capretto concludes that pastoral silence with persons experiencing traumatic loss and grief can offer the assurance that while the caregiver cannot fully enter into the sufferer's experience, "I stand resolutely with you on the shore of your grief."⁴⁶

Hospital chaplains come face to face with trauma and with those who are physically and otherwise wounded by trauma. Such encounters are typically measured in minutes or hours, not

⁴³ Marian Cooper, interview by author, Charlotte, NC, June 22, 2018.

⁴⁴ Zurheide, 12.

⁴⁵ Capretto, 352.

⁴⁶ Ibid., 354-356.

days. But for trauma victims, and those who care for them, the initial exposure to trauma is only the beginning. We consider next the enduring impacts of trauma, and of trauma chaplaincy.

Chapter 4

SHAPED BY TRAUMA – AND BY TRAUMA CHAPLAINCY

Trauma’s ‘Staying Power’. Rambo explores trauma through the lenses of war, and the effects of Hurricane Katrina, which struck the U.S. Gulf Coast in August 2005. Rambo quotes Julius Lee, a church deacon in New Orleans who spoke in January 2008 as local ministers and church leaders discussed the community's ongoing efforts to rebuild. "Things are not back to normal," said Lee. "People keep telling us to get over it already. The storm is gone, but 'after the storm' is always here." As Rambo elaborates, "Trauma is what does not go away. It persists in symptoms that live on in the body, in the intrusive fragments of memories that return." Rambo thus refers to an "ongoingness" that she sees as the "enigma of traumatic suffering."¹

Trauma has tentacles that reach out to touch and impact multiple dimensions of personal, relational, and community life in continuing ways. Noting the interactive relationship between trauma and health, Wainrib observes that "Trauma in itself can create many significant bodily reactions. Conversely, illness, particularly serious illness, can create traumatic responses."² Psychologically, according to Herman, trauma robs a person of their "basic sense of self," violating an individual's autonomy and giving rise to shame and doubt. "In the aftermath of traumatic events," Herman adds, "survivors doubt both others and themselves."³ Rambo starkly

¹ Shelly Rambo, "Spirit and Trauma: A Theology of Remaining," *Interpretation: A Journal of Bible and Theology* Vol. 69 (I) (2015): 8, accessed May 21, 2018, <http://dx.doi.org/10.1177/0020964314552625>.

² Barbara Wainrib, *Healing Crisis and Trauma with Mind, Body and Spirit* (New York: Springer Publishing Company, 2006), 24.

³ Judith Herman, *Trauma and Recovery* (New York: BasicBooks, 1992), 53.

sees trauma as “an open wound, an experience of death that has not ended.”⁴ Thus, for Rambo, the challenge for those who experience trauma is to move in a world in which the boundaries between life and death no longer seem to hold.”⁵

Trauma’s wounds can fester long after they are first inflicted. But research on the aftermath of trauma and observations from therapists suggest that trauma’s lasting marks may also include *positive* forms of personal growth and transformation, for both individuals and communities. Briere and Scott cite the findings of several studies to assert that difficulties and distress can lead to “new levels of psychological resilience,” along with greater self-knowledge, self-appreciation, and empathy.⁶ This perspective is reminiscent of crisis counseling and intervention approaches that emphasize the positive potential of crisis. In this regard, Stone asserts that “even though people may go through considerable emotional pain during a crisis, it can become a positive experience—a chance for growth.”⁷

Trauma’s ‘staying power’ is realized in part by the integration of traumatic experiences into personal and communal narratives. Gillespie observes that “trauma changes a person’s and often a culture’s story.” Noting research on this topic, Gillespie states that “growth occurs when the trauma assumes a central place in the life story.”⁸ The view that loss can lead to positive, personal growth is also evident in some contemporary theories on grief and loss. Kelley summarizes the theme of these newer understandings – that “amid the sadness and struggle, there may be graced dimensions on the road to the new normal. People may be changed in life-giving

⁴ Rambo, 13.

⁵ Rambo, 9.

⁶ John Briere and Catherine Scott, *Principles of Trauma Therapy: A guide to symptoms, evaluation and treatment* (Thousand Oaks, CA: Sage Publications, 2006), 68.

⁷ Howard Stone, *Crisis Counseling* (Minneapolis, MN: Augsburg Fortress Publishers, 1993), 28.

⁸ Gillespie, 20, citing the work of Richard Tedeschi and Lawrence Calhoun in *Trauma and Transformation: Growing in the Aftermath of Suffering* (Thousand Oaks, CA: Sage Publications, 1995).

ways by and through their loss.”⁹ Dykstra expresses this notion by asserting that within the ‘strangeness’ of hospital traumas, “God comes in life-shattering and life-transforming ways.”¹⁰

When the wounds of trauma and the distress of sudden loss and grief are painfully fresh, a direct discussion with victims of the longer-term effects of trauma – either negative or positive – is likely inappropriate. However, chaplains who are mindful of the long-range impacts of trauma may be more fully equipped to offer immediate support to trauma sufferers. In the following section, we explore whether and how chaplain support during hospital trauma situations may play a role in the future well-being of trauma victims and their family members.

The Lasting Impact of Trauma Chaplaincy on Care Recipients. Based on his experiences as a hospital chaplain, Dykstra made the following intriguing observation: “*I had the haunting sense...that the minutes or hours I would spend with these people would be among the most critical of their lives in terms of at least charting the course for the future integration of, or failure to integrate, this crisis into the fabric of meaning in their lives.*”¹¹

The relative brevity of most hospital chaplain encounters with trauma victims and their family members invites the question: ‘How much impact do such visits have after trauma sufferers leave the hospital?’ Responses to this question appear to be largely intuitive, rather than evidence-based. Researchers have noted the limited amount of professional literature on the effects of chaplain interventions in general.¹² Jankowski, Handzo, and Flannelly reviewed multiple studies with hospital patients that did find high levels of overall *satisfaction* with

⁹ Melissa Kelley, *Grief: contemporary theory and the practice of ministry* (Minneapolis: Fortress Press, 2010), 38-39.

¹⁰ Robert Dykstra, “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss,” *The Journal of Pastoral Care* XLIV, 2 (Summer 1990): 152, accessed May 12, 2017, ATLAS.

¹¹ *Ibid.*, 139-140.

¹² Katherine Jankowski, George Handzo and Kevin Flannelly, “Testing the Efficacy of Chaplaincy Care,” *Journal of Health Care Chaplaincy* 17:3-4 (2011): 100, accessed March 19, 2019, <https://doi.org/10.1080/08854726.2011.616166>.

chaplain care. Most patients also felt that chaplains improved their health care by meeting the patients' emotional and spiritual needs.¹³ These findings, however, do not directly address the longer-term impacts of chaplain care in general, nor do they specifically examine how a chaplain's immediate interventions surrounding a hospital trauma event might impact care recipients in the future. Furthermore, Jankowski and colleagues found an absence of studies that clearly document "the efficacy of the unique aspects of chaplaincy care, as opposed to spiritual care provided by an interdisciplinary team."¹⁴

Despite the general lack of hard evidence, there are anecdotal and other reasons to believe that trauma victims or their family members may experience enduring benefits from a chaplain's immediate care at the time of a hospital-based trauma. One such incident is reported by Dykstra, whose quote at the beginning of this section is from an essay published in 1990. Now, decades later, Dykstra remembers his experience in providing spiritual care for one hospital patient who had attempted suicide. Several years later, the woman was readmitted to the same hospital for a procedure. She asked if the chaplain who met with her following her suicide attempt was still employed at the facility. Dykstra recalls that when he responded to visit with her again, she told him that a question he posed to her during the initial encounter years earlier "had propelled her into reexamining her expectations" about happiness in life. She also reported that the dialogue and her reflection on it led her into a 12-step program that "completely changed her life and outlook," even bringing her happiness. The woman told Dykstra that she simply wanted to see him and thank him for their previous conversation.¹⁵

A key principle from the field of crisis counseling also seems to support the notion that

¹³ Jankowski, Handzo, and Flannelly, 111-112.

¹⁴ Ibid., 115.

¹⁵ Robert Dykstra, e-mail message to author, March 20, 2019.

chaplain care during a trauma situation may yield lasting benefits. Swihart states that the first 72 hours of a crisis are critical, and he asserts that “what transpires during these hours will have a long-term impact.”¹⁶ Others have put forth the “wet cement theory” to suggest the benefits of providing prompt help to people who are experiencing a crisis or trauma. Just as cement must be shaped or smoothed before it hardens, according to this theory, “working with a person’s mixture of thoughts, feelings and emotions is generally easier when everything is fresh in the person’s mind.” The early hours of a crisis are also seen as a time when a caregiver may be able to help a person reframe certain ideas or perceptions.¹⁷

As a medical trauma unfolds in a hospital, circumstances and natural human instincts create a sharp focus on the present, which the chaplain will appropriately share. At the same time, a trauma chaplain can seek to offer emotional and spiritual support that may help trauma sufferers move gradually from their present pain, confusion, and distress into the future. Villagos views her role as a chaplain with trauma victims as that of an “escort—somebody to help them get to the other side, almost like a Sherpa.” For Villagos, this means helping to ensure a sense of safety and empowerment for the trauma sufferer and offering emotional and spiritual support for the journey that lies ahead. “I want to think that I’ve laid the groundwork or planted the seeds so they can get to the other side,” Villagos adds. In this sense, ‘short-term’ care by a trauma chaplain that helps meet a trauma victim’s immediate and basic human needs may impact future trauma integration and recovery. Villagos asserts, “It is the post-trauma work; if that person doesn’t feel safe and loved here, they’re not gonna get to take care of their post-traumatic

¹⁶ Judson Swihart, with Gerald Richardson in *Counseling in Times of Crisis*; Resources for Christian Counseling Series, Gary Collins, Gen. ed. (Dallas: Word Incorporated), 139.

¹⁷ Norman Wright, *The Complete Guide to Crisis & Trauma Counseling* (Bloomington, MN: Bethany House Publishers, 2014), 213.

need.”¹⁸

Trauma chaplains encounter patients and family members when they are in the earliest ‘stages’ of grief. As such, the notion of emotional *acceptance* – traditionally seen as the final stage of grief – may seem untimely amid the freshness of devastating traumatic losses. Even so, the first glimmers of acceptance can and do emerge, even amid the shock of sudden death and loss. For example, family members who have just received hospital confirmation of a loved one’s death typically complete the required paperwork and leave the hospital – and body – behind within a few hours. This act of leaving may be viewed as a crucial, first step on the path toward acceptance. The supportive presence, words, actions, or silence of a trained and compassionate chaplain during this process can help provide immediate comfort. In addition, this ministry may convey an unspoken message that will return in future days to help strengthen and heal trauma sufferers. For as Hiltner observes, “all shepherding moves in the direction of healing even though circumstances may prevent actual healing or may prevent it at this time.”¹⁹

The ‘staying power’ of trauma is a reality not only for its direct victims, but also for other people – including chaplains – who are exposed to trauma’s wounds. We examine next how chaplains may be impacted by repeated exposure to trauma, and the importance of self-care for chaplains.

Trauma Exposure and Self-care for Chaplains. “Trauma is contagious.”²⁰ Herman’s simple summation, published in 1992, captured an emerging understanding among mental health researchers and professionals at the time. In the ensuing decades, awareness of the phenomenon

¹⁸ Terri Villagos, interview by author, Charlotte, NC, June 25, 2018.

¹⁹ Seward Hiltner, “The Solicitous Shepherd,” in *Images of Pastoral Care: Classic Readings*, ed. Robert Dykstra (St. Louis, MO: Chalice Press, 2005), 50.

²⁰ Herman, 140.

now often referred to as “secondary trauma” has continued to grow. Researchers and caregivers have also used several related terms, sometimes interchangeably, to describe the effects of repeated exposure to stressful conditions including other people’s trauma and suffering. These terms include *vicarious trauma*, *compassion fatigue*, and the older concept of *burnout*. Mathieu notes the lack of agreement, even among experts, on the precise definitions of these terms. For Mathieu, *compassion fatigue* refers “to the emotional and physical exhaustion that can affect helping professionals and caregivers over time.”²¹ *Vicarious traumatization* is defined by Pearlman as “a negative transformation in the self of a trauma worker or helper that results from empathic engagement with traumatized clients and their reports of traumatic experiences.”²² Pearlman and McKay assert that vicarious trauma does not result from a single encounter with a trauma victim, but rather it is a “cumulative” process. Pearlman and McKay thus describe vicarious trauma as “what happens to you over time as you witness cruelty and loss and hear distressing stories, day after day, and year after year.”²³

Terminology distinctions aside, hospital chaplains whose work brings them repeatedly into close contact with trauma victims and their family members are almost certain to experience some form of secondary or vicarious trauma. As Dykstra observes, “the chaplain inevitably absorbs some of the inherent tension in coming face-to-face with human fragility and the sudden breaking in of death.” According to Dykstra, “ministry to victims of sudden traumatic loss involves a great deal of energy, concentration, piece-meal detective work, and emotional and

²¹ Francoise Mathieu, “Compassion Fatigue,” in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles Figley.

²² Laurie Anne Pearlman, “Vicarious Traumatization,” in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles Figley.

²³ Laurie Anne Pearlman and Lisa McKay, “Understanding & Addressing Vicarious Trauma,” Headington Institute training module, accessed March 27, 2019, https://headington-institute.org/files/vtmoduletemplate2_ready_v2_85791.pdf.

theological risk.”²⁴ Anderson notes that “chaplains are ‘wired’ to be altruistic, self-sacrificing caregivers.” But he states that this altruism can contribute to chaplains’ susceptibility to burnout, compassion fatigue, and symptoms of secondary posttraumatic stress.²⁵

Assessments of the secondary trauma that chaplains can experience highlight the need for good self-care by chaplains. While the scope of this paper does not permit a thorough treatment of this topic, a few points can be noted. Several fundamental aspects of self-care are widely recognized, such a healthy diet, adequate rest and recreation, and exercise. Writing from the context of trauma therapy, Herman asserts that a therapist who works with trauma survivors must have professional support and “attend to the balance in her own professional and personal life.”²⁶ Pearlman and McKay identify three keys to help humanitarian workers of all kinds deal with vicarious trauma – “awareness, balance, and connection.” This approach encourages caregivers to do a regular “self-awareness check,” to maintain balance between work and personal needs, and to maintain meaningful connections with people, communities, and spiritual resources.²⁷

Herman sees three “saving graces” for trauma therapists, including “sublimation,” “humor,” and, “altruism”²⁸ Thus, in light of Anderson’s observation noted above, altruism may be a ‘double-edged sword’ for chaplains and other caregivers, contributing at times to either burnout or survival. An observation by Wicks regarding caregiver stress is pertinent for the trauma chaplain: “Pacing ourselves in how we deal with what is painful around us is not running away. It is respecting that the self is limited and can only deal with so much.”²⁹

²⁴ Dykstra, 145.

²⁵ Michael Anderson, “Secondary Trauma among Chaplains,” in *Encyclopedia of Trauma: An Interdisciplinary Guide*, ed. Charles Figley.

²⁶ Herman, 153.

²⁷ Pearlman and McKay, “Understanding & Addressing Vicarious Trauma.”

²⁸ Herman, 153.

²⁹ Robert Wicks, *Night Call: Embracing Compassion and Hope in a Troubled World* (New York: Oxford University Press, 2018), 54.

Much of the practice of self-care involves the creation and honoring of personal and professional boundaries. This includes knowing when to rely on others – a key principle shared with other forms of crisis care. In Swihart’s words, “Do not try to be the hero and walk a client through a crisis alone.” Swihart encourages pastoral caregivers in crisis situations to “utilize all others who can reasonably make a contribution.”³⁰ For the hospital trauma chaplain, this might include facilitating and embracing the ministry and support of a trauma victim’s pastor, priest, rabbi, or other clergy member.

Jewish tradition offers a helpful perspective on the importance of self-care. Roberts highlights this in discussing disaster-related spiritual care. Self-care in the wake of a disaster is essential, according to Roberts, “if you plan on continuing to be one of God’s caregivers!” He notes the obligation that many providers of spiritual care feel to continue their work “until they are ready to drop.” Citing traditional teaching on Jewish ethics, Roberts suggests that while caregivers have a responsibility to participate in relief efforts, no one must finish the job alone.³¹

For the chaplain, discernment and balance are key factors in assuring quality of care – both outwardly to trauma sufferers, and, inwardly to the chaplain. The chaplain’s task is to hold the ‘other-focused’ and ‘self-focused’ aspects of care in a harmonious relationship. Chaplains may find guidance in this direction through the notion of *self-empathy*, which according to Hunsinger, “gives us the opportunity to listen to our own hearts with the same quality of compassionate attention that we would offer another in our best moments.”³² A trauma chaplain thus attuned to

³⁰ Swihart, 155.

³¹ Rabbi Stephen Roberts, “Jewish Spiritual Care in the Wake of Disaster,” in *Jewish Spiritual Care: A Practical Handbook from Traditional and Contemporary Sources*, ed. Dayle Friedman (Woodstock, VT: Jewish Lights Publishing, 2010), 701. Scribd.

³² Deborah van Duesen Hunsinger, *Bearing the Unbearable: trauma, gospel, and pastoral care*. (Grand Rapids, MI: Wm. B. Eerdmans Publishing Co, 2015), 134, Scribd.

both self and others can fulfill the words of Jesus: “Freely you have received, freely give” (Matthew 10:8, NIV³³). This brings us to a few additional considerations for trauma chaplains.

Chapter 5

FURTHER CONSIDERATIONS FOR TRAUMA CHAPLAINCY

Does Trauma Deserve its Own ‘Theology’? If trauma chaplaincy is a specialized form of ministry, a case could be made that such ministry calls for a specialized theology, i.e., religious and spiritual interpretations that somehow expand or go beyond more traditional and generalized ‘theologies of suffering’. Professional and academic literature addressing this prospect appears to be limited. Bidwell wades into the question with his proposal for development of what he calls a “pneumatraumatology” that would adequately address “the spiritual impacts of trauma.” Bidwell distinguishes this approach from both the techniques of crisis and psychosocial intervention and the resources of systematic theology that chaplains have traditionally relied upon in providing care to trauma sufferers.¹ Dykstra hints at the same need with his assertion that “situations of sudden traumatic loss defy most any theological doctrine or pious practice we might offer by way of consolation.”² While Dykstra and Bidwell open the door to discussion of a customized ‘theology of trauma,’ it is Rambo’s work on this topic that seems most probing and provocative.

Rambo poses the question, “If we are witnessing trauma as suffering in a new key, how does this change the discourse of theology?” She states pointedly that traditional Christian doctrine has failed to adequately encompass the “structure” and “realities” of traumatic suffering. In Rambo’s view, “the study of trauma returns theologians to our primary claims about death and

³³ The Holy Bible, New International Version, Copyright 1973, 1978, 1984 by International Bible Society.

¹ Duane Bidwell, “Developing an adequate ‘pneumatraumatology’: understanding the spiritual impact of traumatic injury,” *The Journal of Pastoral Care & Counseling* 56, 2 (2002): 135-136, accessed July 14, 2017, ATLAS.

² Robert Dykstra, “Intimate Strangers: The Role of the Hospital Chaplain in Situations of Sudden Traumatic Loss,” *The Journal of Pastoral Care* XLIV, 2 (Summer 1990): 149, accessed May 12, 2017, ATLAS.

life, particularly as they are narrated in the events of the cross and resurrection.” Rambo envisions a figurative, “untheologized” place that she describes as “the middle.”³ For Rambo, “the good news of Christianity for those who experience trauma does not rest in either the cross or resurrection, but instead in the movements between the two – in the capacity to witness this middle place and to forge a new discourse between death and life.” Rambo thus suggests that trauma challenges theology to “account for what remains,” for that which “exceeds death yet cannot be interpreted as new life.”⁴

While Rambo’s intriguing ideas may defy an easy grasp, they invite chaplains and all pastoral caregivers to consider the intersection of trauma and theology in fresh ways. Chaplains have a distinct and close-up perspective from which they may ponder deep and difficult questions about God’s place and providence amid the wounds of trauma. A chaplain who engages with such questions humbly and honestly will be better prepared to *hear* the questions of trauma sufferers, help them cope with their present pain, and even envision the future with hope. ***Trauma as Teacher and ‘Lens’***. Pastoral caregivers have traditionally looked to theology and the Scriptures for instruction in how to provide ministry and support to suffering people and those in crisis. Without negating the importance of this method, chaplains and others may also consider the reverse process. Rambo highlights this approach by asserting that “the insights of trauma actually constitute the hermeneutical lens through which an alternate theological vision of healing and redemption emerges.”⁵ That is, rather than interpreting trauma through the lens of Scripture, trauma itself becomes a lens for understanding the Scriptures and their themes.

Similarly, Frechette and Boase note an increasing recognition among biblical scholars that

³ Shelly Rambo, “Spirit and Trauma: A Theology of Remaining,” *Interpretation: A Journal of Bible and Theology* Vol. 69 (I) (2015): 11-12, accessed May 21, 2018, <http://dx.doi.org/10.1177/0020964314552625>.

⁴ Rambo, 13-14.

⁵ *Ibid.*, 16.

the phenomenon of trauma can serve as a “powerful interpretive lens.”⁶ According to this perspective, a “hermeneutics of trauma” can enhance biblical studies in part by highlighting “insights into human experience that reveal meaning not captured by the plain sense of a text.” Frechette and Boase further assert that viewing biblical texts and narratives through the lens of trauma might help present-day survivors formulate personal ‘trauma narratives,’ which can facilitate processing of their experiences and foster “resilience against further traumatization.”⁷

The power of trauma to serve as both ‘teacher’ and ‘lens’ is by no means limited to the realm of Christian theology. Trauma is no respecter of religion. Likewise, the longings, needs and frailties of human nature cross all lines of distinction, including those set forth by religion. Scott appeals for religious and spiritual awareness and inclusivity in trauma care. She highlights the universality of human needs among trauma victims by observing that “spiritual care is juxtaposition to hope, vulnerability, suffering, shame, loneliness, coping, empowerment and comfort.”⁸ Chaplains are in a distinct position to both interpret and learn from trauma through the perspectives offered by people of all faiths.

Leaving, Letting Go, and Living with Mystery. This paper has noted the relative brevity of the typical encounter between a hospital chaplain and a trauma victim or the shock and grief-stricken family members of a person who has died suddenly and unexpectedly. Though brief, these encounters can be emotionally and spiritually *intimate*, as Dykstra has observed. This sense of intimacy, coupled with concern for suffering people, *and* the chaplain’s own emotional or

⁶ Christopher Frechette and Elizabeth Boase, “Defining ‘Trauma’ as a Useful Lens for Biblical Interpretation,” in *Bible Through the Lens of Trauma*, ed. Elizabeth Boase and Christopher Frechette (Atlanta: SBL Press, 2016), 1, accessed January 27, 2019, JSTOR.

⁷ Frechette and Boase, 13-15.

⁸ Tricia Scott, “Religion in trauma care: grand narratives and sacred rituals,” *Trauma* 12 (2010): 190, accessed April 9, 2017, 10.1177/1460408610376708.

psychological needs, may cause the chaplain to feel reluctant to ‘let go’. Discernment, self-awareness, and careful observation of ‘clues’ from patients or family members can help guide the chaplain’s decisions about when to step away or bring closure to a caregiving encounter. Inspiration in this regard for chaplains may be found in the earthly ministry of Jesus, who dramatically changed lives, often not in lengthy encounters, but as he was ‘passing by’ (e.g., Luke 19:1, John 9:1).

Inherent in chaplaincy – and often powerfully present in the wake of hospital trauma encounters – is a lingering sense, for the chaplain, of mystery. Learning not only to live with, but even to *embrace* such mystery, is a key part of the calling for those who would come alongside people who are suffering from the fresh wounds of trauma.

CONCLUSIONS, REFLECTIONS, AND SUGGESTED RESEARCH

Assessing this Paper's Goals and Outcomes. My Integrative Paper proposal stated that my research would examine “the theological, clinical and pastoral tasks encountered by healthcare chaplains in hospital trauma settings.” I outlined a research approach to include professional and academic literature, shadowing of and interviews with trauma chaplains, and exploring relevant theological themes and biblical perspectives.

Approximately fifty sources are cited in this paper. Utilizing literature from multiple disciplines proved beneficial. For example, I found that Judith Herman's classic work *Trauma and Recovery*, while not written with chaplaincy in mind, contained pertinent insights for my topic. Likewise, the literature on crisis counseling and intervention helped me discern pastoral care foundations that contributed to the development of professional healthcare chaplaincy. At the same, I saw that the methods of traditional crisis counseling are not synonymous with those of hospital chaplaincy. For example, there appears to be a greater tendency at times among pastoral crisis counselors to quickly encourage people in crisis situations to envision how the crisis may lead to positive outcomes.

My ‘shadowing’ of two chaplains at Atrium Health/Carolinas Medical Center's Level One trauma hospital in Charlotte, North Carolina provided excellent insights gleaned through the author's observations and interviews with the chaplains.

A particular challenge in addressing my paper's objectives was the quest to discover existing literature that might help chaplains or others develop a specific “theology of trauma”.

Outside of the sources cited in this paper and summarized in Chapter 5 (primarily Rambo, Bidwell, and to some degree, Dykstra), I did not find research that explicitly addresses this issue. Limited literature, coupled with the sweeping scope of this paper and research effort, prompted me to relinquish my goal of offering a ‘framework’ for developing a theology of trauma.

This paper synthesizes a large body of subject matter, including fundamentals of the trauma phenomenon, the dynamics and practice of hospital trauma chaplaincy, and the potential lasting impacts of trauma and chaplain care on trauma victims and chaplains alike. The ‘backbone’ of the paper is Chapter 3, on “The Practice of Chaplaincy in Hospital Trauma Scenarios.” The author’s “PAWS” model for trauma chaplaincy, encompassing the ministries of Presence, Actions, Words, and Silence, offers a fresh and easily-remembered framing of pastoral care and chaplaincy fundamentals. I believe that the information and perspectives offered in this paper and briefly outlined in the accompanying PowerPoint presentation could be a helpful resource for chaplains and for CPE educators and students.

The Author’s Journey in Researching and Writing this Paper. In my proposal for this paper, I stated that “I am both awed and intrigued by the intimate, mysterious, and profound nature of spiritual care that is provided in times of trauma.” I believe that significant seeds for this research and writing endeavor were planted in the early morning hours of an August day in 2015 during my ministry as a chaplain intern to the family of a 25-year old woman who died in the ICU after her condition unexpectedly turned extremely critical (an encounter referred to briefly in Chapter 2 of this paper). It was also during this unit of CPE that I encountered Dykstra’s “Intimate Strangers” essay, which resonated strongly with me and highlighted for me the dynamics of hospital chaplaincy in cases of sudden, traumatic death. By early 2017, I had begun to envision the possibility of writing my final seminary paper on the topic of trauma chaplaincy.

My interest in this topic has been sustained through several influences including ongoing service as a volunteer hospital chaplain, seminary studies concentrated in the area of pastoral care and counseling, and my plans to begin a CPE residency.

My research and engagement with this topic has been personally instructive and I anticipate that it will yield enduring results. For example, I have become better informed about the phenomena of secondary trauma and ‘vicarious traumatization’. I have also recognized a need for me to further consider and develop my own views on God’s place in the midst of trauma. In addition, specific phrases from quoted material are engrained in my mind, such as Dykstra’s “haunting sense” about the lasting impact of trauma chaplaincy, Rambo’s “razed terrain” of that which remains following a traumatic event, and Switzer’s counsel to use “authentic, concrete words” with people who are experiencing a crisis. These and other nuggets from my research and writing are likely to return to me in future times of chaplaincy practice and reflection.

My immersion in the topic of hospital trauma chaplaincy has also fed my anticipation of the CPE residency I will begin in a few months in a Level One trauma facility. This includes ‘positive’ anticipation and a certain sense of increased readiness for such an experience, as a result of my research, reflection and writing. At the same time, this academic project has also reinforced and expanded my awareness that chaplaincy is a demanding, and at times *draining* endeavor – emotionally, mentally, physically, and spiritually. I wonder how I will react and respond during future hospital trauma scenarios and how my presence and role as a chaplain will impact patients, family members, and hospital staff. And, I ponder how I as a person will be impacted *by* my caregiving and my “vicarious” absorption of trauma, and how I can ensure appropriate self-care.

A Final Reflection. “Surely he has borne our griefs and carried out sorrows; ...he was pierced for our transgressions, he was crushed for our iniquities; upon him was the chastisement that brought us peace, and with his wounds we are healed” (Isaiah 53:4-5). The familiar messianic prophecy seems to carry a freshly poignant nuance, in light of this paper’s perspectives on trauma and trauma chaplaincy. It is a profound thought that Christ was crushed – wounded – *traumatized* –to atone for personal sins and for the sins of the world and of the ages. It is humbling to consider that it is this same Christ – the ‘Suffering Servant’ – whose presence may, in some sense, be represented by the presence of a chaplain to those who suffer the piercing wounds of fresh trauma. In such circumstances, a sustaining and healing divine presence is surely needed by traumatized persons – *and* by the thoroughly human chaplains who seek to spend a few moments or hours sharing the gifts of empathetic presence, supportive actions, caring words, and/or compassionate silence.

Suggestions for Further Research. This paper has noted an apparent paucity of research and literature that would provide clear or compelling evidence regarding the long-term impact of chaplain care received specifically during hospital trauma situations. The author proposes that targeted research on this question could provide valuable information and context for chaplains, hospital spiritual care departments, clinical staffers, and administrators. Potential challenges for this type of research could include privacy concerns and the need for sensitivity in post-trauma contacts or surveys involving former patients or family members of patients who died.

The notion of developing a specifically-tailored ‘theology of trauma’ also appears ripe for further study. Perhaps the first task would be to more clearly define and demonstrate a need for such a theology. Research could then explore how the discernment and application of a ‘theology of trauma’ might help shape the care provided by hospital chaplains, the future well-being of

care recipients, and the spiritual and emotional health of chaplains themselves.

This author also recommends additional research that would focus on the persons who serve as trauma chaplains. Such studies might examine personality traits, life experiences, or other factors that help attract individuals to this specific form of chaplaincy. Research could also further explore the specific risks and manifestations of secondary or vicarious trauma in chaplains, along with effective forms of self-care or other measures to ameliorate its potentially harmful effects.

Finally, this paper assumes scenarios in which chaplains, by hospital policy and protocol, routinely participate in the care that is provided to trauma victims and their family members in emergency departments and intensive care units. However, variations exist in terms of hospital policies and internal ‘cultures’ in this regard, such as whether or not chaplains automatically respond to all ‘alerts’ for incoming trauma cases. Future research could explore how hospital protocols and cultures regarding the role of chaplains impact the overall care provided in trauma situations, as well as patient or family member perceptions of such care.

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